GENERAL

REPORTING

Reasonable Costs

The provision of Nursing Facility Care Services to Medicaid recipients is provided only to those individuals who are eligible for nursing facility services in accordance with Medicaid regulations relating to resources and income. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Department of Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. These Principles of Reimbursement, through application of rate ceilings, provide for payment of Nursing Facility Care services under the Medicaid Program on a prospective basis through rates that are reasonable and adequate to meet costs that must be incurred by efficiently and economically operated nursing facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those cost of an individual facility for items, goods and services which, when compared, will not exceed the costs of like items, goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a

given item or service. Where it is determined that reported costs exceed those levels and in the absence of proof that the situation was unavoidable, the excessive costs will be disallowed.

In the absence of specific definitions and/or elements of allowable and disallowable costs that may not be contained herein, the Rules and Regulations of Federal Medicare - Title XVIII will prevail.

The State reserves the right to make determinations of allowable costs in areas not specifically covered in the Principles or in the Rules and Regulations of Federal Medicare - Title XVIII.

Upper Limits

In no case may payment exceed the facility's customary charges to the general public or the federal upper payment limit for such services. The Upper Payment Limit is based on reasonable cost as is our payment.

Annual Cost Report BM-64

All facilities must file an annual cost report BM-64 on a calendar year. The report format is determined by the Center for Adult Health’s Rate Setting Unit and must be filed on or before March 31 following the close of the year.

Newly constructed facilities will be allowed a temporary rate subject to the submission to the Chief Long Term Care Reimbursement of a BM-64 cost report covering a six-month period from the beginning of operations. The rate will be determined in the manner described for all other facilities under these principles and subject to the same ceilings.

The report must be completed in accordance with generally accepted accounting

principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit the BM-64 on time without written authorized extension from the Rate Setting Unit will be assigned a non-recoverable reduction of 20 percent of the previously assigned rate. Such rate reduction will continue on a month-to-month basis until said BM-64 is submitted or facility is terminated from the program for failure to file BM-64 report within six months from the close of the reporting year.

A final BM-64 must be filed within 90 days after a change in ownership, closing of the facility or when the provider leaves the Medicaid program.

ADMISSION POLICY

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination in accordance with the provisions of Section 23-17.5-19 and 23-27.5-21 of the Rhode Island General Laws based solely upon specialized medical and related needs of the patient. In addition, as provided in Section 23-17.5-24 of the Rhode Island General Laws, patients shall have the right to remain in a facility after the depletion of private funds.

PARTICIPATION ~~AND PAYMENTS~~

Facilities and at least 25% of all their nursing facility beds must be dually certified for participation in both the Federal Medicare - Title XVIII Program and the Rhode Island

Medical Assistance - Medicaid Title XIX Program on and after October 1, 1990. Ideally all nursing facility beds should be dually certified.

The Director of the Department of Human Services may waive the requirement for Medicare certification upon his or her determination, upon consultation with the director of the state surveying agency, that: (1) there is an imminent peril to public health, safety or welfare; and/or (2) it is in the best interest of the state and the residents of the facility.

METHOD FOR DETERMINING COST CENTER CEILINGS

~~**NOTE:** Effective for October 1, 2003, there is a continuation of the calculation of the ceilings for two cost centers. This calculation will continue until September 30, 2005 for the Management and All Other Cost Centers.~~

~~On September 1, 2004, the Other Property Related Cost Center will be replaced by the Fair Rental Value System in the Property Cost Center, Reimbursement for that cost center will be such that a ceiling will not be calculated. Effective October 1, 2005, ceilings for the Management and All Other Cost Center will be replaced by a ceiling for the Other Operating Cost Center. The Other Operating Cost Center ceiling will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) at 125% of the median for facilities for the most current array year.~~

~~BM-64 Cost Reports for calendar year 1991 for all certified and participating nursing facilities in continuous operation from January 1, 1991 through December 31, 1991, will be grouped into one level of care category and allowable cost per diems will be arrayed in descending order into the following two cost center per diem groupings: (a) All Other Expenses, and (b)Management Related Expenses. The appropriate percentiles as~~

~~specified below will then be applied to this arrayed data and will be increased by the annual percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services for rate years 1992 and 1993 and each subsequent July 1 beginning with the percentage adjustment recognized July 1, 1994,~~

~~BM-64 Cost Reports for the calendar year 2002 for all certified and participating nursing facilities (except for the Hospital Based Skilled Nursing Facilities) will be grouped and allowable cost per diems will be arrayed in descending order into the Direct Labor Cost Center. The appropriate percentile, 125% of the median for Direct Labor, will be applied to the arrayed data and will be increased by the percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services effective July 1, 2003 and then each subsequent October 1st. Costs in the Direct Labor Cost Center will be arrayed every three years, the next array year being calendar year 2005 to establish a new maximum effective October 1, 2006.~~

a. **Pass Through Items:**

The Pass Through Cost Center is such that a ceiling maximum is not calculated. This cost center grouping will include allowable costs reported in all account numbers as listed in Appendix 'C' – Chart of Accounts. ~~Costs will be allowed without regard to a ceiling maximum.~~ Each facility will report in Account No. 8470 the expenditure for the Health Care Provider Assessment. The costs in this item attributable to program revenue received will be fully recognized for reimbursement through an add-on to the per diem rate equal to the Health Care Provider Assessment as compounded.

b. **Direct Labor:**

This cost center grouping will include allowable costs in all account numbers as listed in Appendix 'C' – Chart of Accounts. Costs will be allowed up to a ceiling maximum of 125% of the median of the costs of all facilities arrayed.

BM-64 Cost Reports for the calendar year 2002 for all certified and participating nursing facilities (except for the Hospital Based Skilled Nursing Facilities) will be grouped and allowable cost per diems will be arrayed in descending order into the Direct Labor Cost Center. The appropriate percentile, 125% of the median for Direct Labor, will be applied to the arrayed data and will be increased by the percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services effective July 1, 2003 and then each subsequent October 1st. Costs in the Direct Labor Cost Center will be arrayed every three years, the next array being calendar year 2005 to establish a new maximum effective October 1, 2006.

~~Nursing facilities whose allowable 2002 direct labor costs are below the median in the direct labor cost center may make application to the Department's Rate Setting and Auditing Unit for a direct labor cost interim payment adjustment equal to twenty-five (25%) of the amount such allowable 2002 direct labor costs are below the median. This interim payment adjustment will be granted on or after October 1, 2003. The interim payment adjustment must be expended on expenses allowable within the direct labor cost center and any portion of the interim payment not expended on allowable direct labor cost center expenses will be subject to retroactive adjustment and recoupment by the Department. The Department will determine the final direct labor payment adjustment after review of the facility's actual direct labor expenditures. The final direct labor payment adjustment will be~~

~~included in the facility's October 1, 2004 rate until the facility's next base year.~~

c. ~~**All Other Expenses:**~~

~~**NOTE:** This cost center grouping will be combined with the Management cost center group effective October 1, 2005 to form the Other Operating cost center. A ceiling maximum at that time will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) of the median for all facilities for the most recent array year.~~

~~This cost center grouping will include all other allowable costs not specifically covered by grouping a, b, d Costs will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities arrayed until October 1, 2005.~~

d. ~~**Management Related Expenses:**~~

~~**NOTE:** This cost center grouping will be combined with the All Other Expenses cost center group effective October 1, 2005 to form the Other Operating cost center. A ceiling maximum at that time will be established by the Department between ninety percent (90% and one hundred fifteen percent (115%) of the median for all facilities for the most recent array year.~~

~~This cost center grouping will include all allowable costs reported in Accounts No. 7411-Administrator, 7412 - Officers/Owners, 7421 - Other Administrative Salaries, 7431 - Health Care Plan (Employer's share-portion attributable to personnel included within this cost center), 7432 - Other Employee Fringe Benefits (portion attributable to personnel included within this cost center), 7433 - Home Office/Central Services (portion attributable~~

~~to labor and payroll-related expenses), 7435 - Computer Payroll/Data Processing Charges, 7436 - Accounting/Auditing Fees, 7437 - Legal Services, 7440 - Payroll Taxes (portion attributable to personnel included within this cost center), 7442 - Insurance (Workers Compensation, group life, pension and retirement-portion attributable to personnel included within this cost center), 7444A -Utilization Review Medicaid Title XIX, 7449A - Miscellaneous Management Related, 7523 - Dietary Consultant, 7712 - Pharmacists Salaries/Fee and effective September 1, 1996 cost will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities until October 1, 2005.~~

c. **Fair Rental Value System**:

The Fair Rental Value System is such that a ceiling maximum is not calculated.

d. **Other Operating Cost Center**:

This cost center grouping will include allowable costs in all account numbers as listed in Appendix 'C' – Chart of Accounts.

BM-64 Cost Reports for the calendar year 2002 for all certified and participating nursing facilities (except for Hospital Based Skilled Nursing Facilities will be grouped and allowable cost center per diems will be arrayed in descending order in the Other Operating Cost Center. The appropriate percentile, 105% of the median for the Other Operating Cost Center, will be applied to the arrayed data and will be increased by the percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services effective July 1, 2003 and then each subsequent October 1st. Costs in the

Other Operating Cost Center will be arrayed every three years, the next array being calendar year 2005 to establish a new maximum effective October 1, 2006.

METHOD OF DETERMINING INDIVIDUAL PROSPECTIVE RATES

~~**Note:** Due to the changes to the Principles of Reimbursement effective October 1, 2003, certain rate calculations remain in effect until October 1, 2005. This applies to the Other Property Related Cost Center, (until September 1, 2004), All Other Cost Center and Management Cost Center. These calculations are listed in numbers 1 through 5.~~

~~1. Each facility in operation during calendar year 1991 shall have its base year established in accordance with 'Appendix A' Audit Scheduling for all cost centers described in a., b., c., d above. Any facility commencing operation subsequent to calendar year 1991, shall have its first six months of operation as its base period.~~

~~2. Effective July 1, 1993, each facility will be assigned interim prospective rates utilizing the facility's base year BM-64 cost report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the audited year up to and including rate year 1993 and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999 and subject to cost center maximums described in c., d., above. The interim prospective per diem rate will be adjusted, if necessary, through results of an audit of base year costs.~~

~~3. An additional interim per diem rate will be calculated and added to each nursing facility rate to recognize reimbursement for expenditure in account #8470 Health Care Provider Assessment for Rhode Island Medical Assistance Program revenue.~~

~~4. Starting with the reporting year 1991 and with every reporting year thereafter, one-third of the participating facilities will have a new base year. The prospective rate of each facility with a new base year will be recalculated after the completion of an audit and will be effective July 1 of the year subsequent to the year in which the audit was scheduled. The recalculated rate will reflect the actual allowable costs as determined by the audit updated by the National Nursing Home Input Price Index percentage increase(s) for the year(s) subsequent to the audited year, and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999, to produce the prospective rate; provided, however, that the new prospective rate does not exceed the maximum rates established for each cost center ceiling.~~

~~5.~~ 1. ~~Commencing with the State fiscal year beginning July 1, 1994 and each State fiscal year thereafter, excluding however the rate year July 1, 1996 through June 30, 1997, the annual percentage increase will be applied to all cost centers determine new cost center ceilings. Commencing July 1, 1994, excluding however the rate year July 1, 1996 through June 30, 1997,~~ Individual facility cost center rates (excluding the Fair Rental Value System Cost Center) will be adjusted annually by the amount of percentage change in the National Nursing Home Input Price Index for the twelve (12) month period ending the previous March. The amount of percentage change to be utilized will be the index as projected by the Centers for Medicare and Medicaid Services on the first date it is available in the month

of May each year. Although the index may be obtained initially by telephone, it will be confirmed in writing.

2. Effective October 1, 2003 for the Direct Labor and Pass Through Items Cost Center, each facility will be assigned interim prospective rates utilizing the facility's base year 2002 BM-64 Cost Report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the base year. Each facility will have a new interim rate assigned each October 1st in these two (2) cost centers, based on the immediate prior calendar year cost report, increased by the recognized percentage change applied as of July 1. The interim prospective per diem rate will be adjusted, if necessary, through results of a desk/field audit of base year costs for the Direct Labor and Pass Through Items Cost Center.

3. Effective October 1, 2005 for the Other Operating Cost Center, each facility will be assigned an interim prospective rate utilizing the facility's base year 2004 BM-64 Cost Report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the base year. Each facility will have a new interim rate assigned each October 1st in this cost center, increased by the recognized percentage change applied as of July 1. The interim prospective rate will be adjusted, if necessary, through results of a desk/field audit of base year costs for the Other Operating Cost Center.

Temporary Rates for Newly Constructed Facilities

Newly constructed facilities will be allowed a temporary reimbursement rate after supplying the Chief Long Term Care Reimbursement sufficient cost data or other information necessary to fairly calculate interim per diem rates, subject to the maximum cost center ceilings. Upon completion of a six-month period from time of licensure, the facility will complete and file with the Chief Long Term Reimbursement for Nursing Facilities, a cost report form BM-64 covering the first six months of operations. Based upon the analysis of the report and Principles of Reimbursement in effect at the time of licensure, a new rate may be calculated, subject to the maximum cost center ceilings as established, and made retroactive to the date of licensure

Proforma cost data and BM-64 cost reports covering the first six month of operations submitted by newly constructed facilities will not be considered in the array of cost information for the determination of the maximum allowable base in each of the cost center category.

APPEALS PROCESS

~~**NOTE:** This section on appeals process will be amended effective October 1, 2005 to include a provision that it shall apply to demonstrated errors made during the rate determination process.~~

Any provider who is not in agreement, after being provided an exit audit conference or rate appeal conference, with the final rate of reimbursement assigned as the result of the audit for their base year, or with the application of the Principles of Reimbursement for the applicable calendar years, may within 15 days from the date of notification of audit

results or rate assignment file a written request for a review conference to be conducted by the Associate Director, Division of Health Care, Quality, Financing and Purchasing, or other designee assigned by the Director of the Department of Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Associate Director or designee shall schedule a review conference within 15 days of receipt of said request. As a result of the review conference, the Associate Director or designee may modify the audit adjustments and the rate of reimbursement. The Associate Director or designee shall provide the provider with a written decision within 30 days from the date of the review conference.

Appeals beyond the Associate Director or the designee appointed by the Director of the Department of Human Service's will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than 15 days of the decision noted in the paragraph above.

APPEAL REQUESTS FOR RATE INCREMENTS

~~**NOTE:** This section on appeal requests with the exception of item f. is hereby repealed in its entirety effective October 1, 2005.~~

~~In those cases in which the assigned prospective rate of a facility falls below the new aggregate ceiling maximum, the Department of Human Services can consider the granting of a prospective rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase. In order to qualify for such a rate increment, demonstrated increased costs must be a result from:~~

~~a. Demonstrated errors made during the rate determination process,~~

~~b. Significant increases in operating costs resulting from the implementation of new or additional programs, services or staff specifically mandated by the Rhode Island Department of Health,~~

~~c. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with Fire Safety Codes and/or Certification requirements of the Rhode Island Department of Health, or,~~

~~d. Significant increases in Workers Compensation and/or Health Insurance premiums which cannot be accommodated within the facility's assigned aggregate per diem rate will be allowed a rate increment, if cost justified, so long as the new assigned per diem rates in the Labor Related Expenses cost center and in the Management Related Expenses cost center do not exceed two-percent (2%) of said cost center ceilings, or,~~

~~e. Extraordinary circumstances, including, but not limited to, acts of God, and inordinate increases in energy costs (e.g., federal BTU tax, regional or national energy crisis). Inordinate increases in energy costs will be immediately reflected in increased rates above the energy cost center ceiling maximum. Provided, however, that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.~~

~~Initial requests for prospective rate adjustments in excess of those that would be established through application of established percentage increase, will first be reviewed by the Rate Setting Unit within the Center for Adult Health within the Department of Human Services. This Unit will be empowered to grant such variances, provided that the facility involved meets the above criteria and provides all the necessary data.~~

~~Requests for rate increments will be limited to one request per annum per facility for the factors specified in items (b) (c) and (d) above. However, additional requests involving~~

~~a recurring per diem increase in excess of one percent of the facility's previously assigned aggregate per diem rate will also be reviewed. Before a facility files for a rate increment, increases in operating costs addressed in (b) (c) and (d) above must have been incurred for at least a three-month period in order to establish proof of such increase.~~

~~All costs, including salaries, must be absorbed within these group ceilings. The total ceiling maximum will be the sum total of the cost center ceilings.~~

The Department of Human Services can consider the granting of an appeal request for rate increments under the following circumstances:

Demonstrated Errors

a. In those instances where a provider can provide evidence of a demonstrated error made during the rate determination process, an appeal may be granted. The provider must file a request in a timely manner for review with the Rate Setting Unit, Center for Adult Health identifying the details of the error. The Rate Setting Unit will be empowered to grant the rate appeal provided the facility submits all the necessary data.

Enterprise Zone

b. ~~f.~~ ~~In addition to the above appeal request~~, A facility may qualify for a rate increment adjustment ~~as determined by the department~~ in accordance with this ~~sub-~~section:

(a) The facility is located in a federally designated Enterprise Community; and

(b) The facility is incurring allowable costs in one or more cost centers in excess of the

allowable maximum for such cost center(s); and

(c) The facility files a written request for a rate increment with the department which must include the following documentation:

i. A cost containment and revenue enhancement plan; and

ii. A cost report for the most recently completed six (6) months of operations; and

iii. Such other documents as may be requested by the department.

The department shall review the written request and may grant a rate increment adjustment to become effective not earlier than the month the request was filed which:

1. may result in a per diem rate which shall not exceed the aggregate of all cost center maximums, plus the per diem rate to recognize reimbursement for the health care provider assessment in account #8470; and
2. will be limited for a period not to exceed twenty-four (24) consecutive months; and the facility may reapply for a rate increment adjustment under this subsection for a period of twenty-four (24) consecutive months following the month of expiration or termination of an approved rate increment adjustment; and
3. subject to the aggregate limit in (1) above, may recognize reasonable and necessary costs incurred by the facility to achieve the cost containment/revenue enhancement plan approved by the department; and
4. will be established for an initial six (6) month period, and may be extended and adjusted by the department for an additional six (6) month periods (but not to exceed the overall maximum twenty-four (24) month limit); and
5. will be subject to continuing review and monitoring by the department and such terms and conditions to be specified by the department in a rate increment approval letter

(for initial and extended periods) to the facility.

~~Rate adjustments granted as a result of a request filed within 120 days after the costs were first incurred will be made effective retroactively to the date such costs were incurred. However, any adjustments granted as a result of requests filed beyond 120 days after the costs were first incurred will be effective on the first day of the month following the filing of the request.~~

c. Special Prospective Rate Appeal – Any facility that has been directed by the Department of Health to appoint an independent quality monitor, engage an independent quality consultant or temporary manager and/or develop and implement a plan of correction to address concerns regarding resident care and coincident financial solvency may file for a Special Rate Appeal. The Special Rate Appeal components are as follows:

a. The provider must submit a written request (including a copy of the plan of correction) to the Department of Human Services, Rate Setting Unit.

b. The request must be based on the approved spending plan set forth in the plan of correction and remediation.

c. The provider must submit evidence that the approved spending plan cannot be accommodated by the existing per diem rate.

d. The rate appeal will not be for a period of less than six-months.

e. The Department, at its discretion, may provide for subsequent extensions for six-month periods for a maximum total period of twenty-four months.

f. The provider must submit a BM-64 Cost Report for each six-month appeal period.

g. The Department will recoup any funds not expended during the six-month appeal period.

h. In calculating the Special Prospective Rate Appeal, the Department will disregard cost center ceiling maximums for the Direct Labor and Other Operating Cost Centers.

i. Upon conclusion of the six-month period (or subsequent extension periods) , the per diem rate will revert to what the provider's normal base period rate calculation would be.

PAYMENTS

The State of Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate. This also applies to State only days.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is prohibited.

RECORDKEEPING

Adequacy of Cost Information

Providers of Long Term Care under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledgers, books and source documents (invoices, purchase orders, time cards or other employee attendance data, etc.). All records must be physically maintained within the State of Rhode Island.

Census Data

Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must be in agreement with monthly attendance reports and shall be the denominator used in the computation for determining per diem rates providing that said patient days are equal to or greater than 98% of the statewide average occupancy rate of the prior calendar year. In calculating patient days the date of admission is counted as one day, however, the date of death or discharge is not counted as a day.

AUDIT OF PROVIDER COSTS

In accordance with 45 CFR-250.30 p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial and statistical records of each participating provider in operation.

Audits will be conducted under generally accepted auditing standards and will insure that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs. Costs of new construction may be audited by the State as herein described. Services and affiliated organizations where common ownership exists shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups.

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

OPERATING COSTS

Property Payment – Fair Rental Value System (FRV)

The property payment effective September 1, 2004 will be a Fair Rental Value System(FRV) which will provide a payment in lieu of the Other Property Related Cost Center. This will eliminate reimbursement for depreciation, interest, rent, and/or lease payments on property, plant and equipment, working capital interest, all other interest, and vehicle depreciation and/or lease payments. The Fair Rental Value System (FRV)

establishes a facility's value based on its age. The older the facility, the less its value. Additions and renovations (subject to a minimum per bed limit) and bed replacements will be recognized by lowering the age of the facility and, thus increasing the facility's value. The facility's established value is not affected by sale or transfer and new facilities will be assigned a rate based upon a completed survey. All Fair Rental Value Surveys are subject to field audit.

The Fair Rental Value System payment rate received by a facility as of September 1, 2004 shall be no lower than the Other Property Related Cost Center payment rate received as of June 30, 2004. <u>This rate will remain in effect until such time the Fair Rental Value System rate exceeds the facility rate received as of June 30, 2004.</u>

The parameters of the Fair Rental Value System and the start up of the system are as follows:

1. The initial age of each nursing facility participating in the Medicaid Program and used in the FRV calculation shall be determined as of September 1, 2004 utilizing a statewide survey to determine each facility's year of construction and date of entry into the Medicaid program. In addition, this age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built.
2. A bed value, based on a standard facility size of 450 square feet per bed, will be determined using the R.S. Means Building Construction Data Publication or a comparable valuation system adjusted by the location index for Providence, Rhode Island. The bed value for September 1, 2004 is determined to be $ 66,000. per bed.

This value per bed includes an amount of $4,000. per bed for equipment.

3. The value will be increased by a factor of 10% to approximate the cost of land and other soft costs.
4. For each facility, the trended value will be depreciated, except for the value portion assigned as land, at a rate of 1.5% per year based upon the weighted age of the facility. Bed replacements, additions and renovation shall lower the weighted average age of the facility. The maximum age of a nursing home shall not exceed 35 years.
5. The value assigned shall be trended forward annually to the mid point of the rate year (starting July 1, 2005) based on the percentage change in the R. S. Means Construction Cost Index, or comparable index, for the previous calendar year end up to a ceiling of four (4.0) percent.
6. A nursing facility's Fair Rental Value (FRV) is calculated by multiplying the facility's current value per bed times the number of licensed (including beds approved as out of service) times a rental factor. The rental factor will be the 20-year Treasury Bond Rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year plus a risk factor of 3.0 percent with an imposed floor of 9.0 percent and a ceiling of 12.0 percent. The rental factor to be utilized for September 1, 2004 will be 9.0 percent. The first recalculation of the rental factor will occur effective July 1, 2005.
7. The calculated Fair Rental Value (FRV) shall be divided by patient days for the cost reporting period. Patient days are based upon the higher of the actual census or 98% of the statewide average for all facilities included in the Fair Rental Value

calculation. For start up of the Fair Rental Value System, this is considered to be calendar year 2002 for FRV rate assignment effective September 1, 2004. For rate calculations July 1, 2005 and subsequent, the census will be predicated on the previous calendar year <u>patient days provided that such patient days are greater than 98% of the statewide average occupancy rate of the prior calendar year.</u>

8. The age of each facility will be further adjusted each July 1, to make the facility one year older, up to the maximum age, and to reduce the age for those facilities that have completed and placed into service major renovations, bed additions or replacements.

9. As previously noted, the age of each facility is adjusted for major renovations, bed additions and replacements. These changes will be averaged into the age of the facility the July 1st following the year the major renovations were placed in service or year beds were placed in service. Major renovations are defined as a project, or series of projects, with capitalized cost equal to or greater than $1000. per bed. This is calculated on a calendar year basis.

10. Continued explanation and examples of the Fair Rental Value System (FRV) are as follows:

    A. Facility of 120 beds, constructed in 1994, with no major renovations or bed additions and occupancy of 95.0%.

Value per bed	$ 66,000.
Number of beds	120
Value (value per beds x beds)	$ 7,920,000.
Accumulated Depreciation (1.5% x 10 yrs. = 15.0%)	$ 1,188,000.

Net Value (value less accumulated depreciation)	$ 6,732,000.
Land Value (10% x value per bed x # of beds)	$ 792,000.
Total Value	$ 7,524,000.
Fair Rental Value Return (total value x 9.0%)	$ 677,160.
Fair Rental Value Per Diem Rate(41,610 patient days)	$ 16.27

B. Example of bed addition – The addition of beds will require a computation on the weighted average age of the facility based on the construction dates of the original facility and the additional beds placed in service.

Facility of 120 beds, constructed in 1994, which added 40 beds in 1999.

Beds	Age	Weighted Average
120	5 (1999-1994)	600
40	0	0
160		3.75

New Base year 1995 (1999 – 3.75)

As compared to 1999

C. Renovation or major improvement – The cost of major renovations and improvements are factored into a facility's age provided that they meet the definition that it is a project with capitalized cost equal to or greater than $1,000. per bed. This is based on a calendar year basis. Renovation/improvement cost must be documented through cost reports, depreciation schedules, etc. and are subject to audit. Costs must be capitalized in order to be considered a renovation or improvement. Individual assets with a cost of $500.00 or more and a useful life of at least 3 years must be capitalized. Useful lives for assets acquired after September 1, 2004 are determined by utilizing the American

Hospital Association (AHA) guidelines of Depreciable Hospital Assets, 1998 edition or subsequent. Assets acquired in quantity at a total cost of $1,000. or more and multiple purchases of similar individual assets during a reporting period must be capitalized if the useful life is three years or more. In establishing the age of a facility, renovations/improvements are converted into an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility. The equivalent number of new beds will be determined by dividing the project cost by the construction cost of a new bed in the year of the renovation/improvement project. Refer to Appendix 'E"D' for historical cost data indexes.

Example : Facility of 120 beds, constructed in 1994 and had a major renovation project totaling $1,000,000. in 2000.

Cost of renovation $1,000,000. divided by replacement cost index in 2000 of $60,443. equals 16.54 beds (figure cannot exceed total number of beds).

Beds	Age	Weighted Average
16.54	0	0
103.46	6	620.76
120.00		620.76
		5.17

New base year 1995, as compared to 2000.

D. Replacement of Beds – The replacement of existing beds will result in an adjustment to the age of the facility. A weighted average age will be calculated according to the year of initial construction and the year of bed replacement. This differs from the addition of beds in that a certain number of beds have replaced those that were initially constructed.

If a facility has a series of additions or replacements, it is assumed that the oldest beds are ones being replaced.

Example: Facility of 120 beds, constructed in 1984, replaced 40 beds in 1999.

Beds	Age	Weighted Average
40	0	0
80	15	1200
120		1200
		10.00

New base year 1989 (As compared to 1999)

Transportation Vehicles

The allowance for expenditures , including but not limited to, gas, oil, repairs, insurance, taxes on vehicles used to transport patients and for other official business purposes is based on the following schedule:

NUMBER OF BEDS	VEHICLES ALLOWED
35 or less	1 vehicle
36 - 75	1 1/2 vehicle
over 75 beds	maximum of 2 vehicles

Recreation vans (RV) - no allowance will be recognized.

1-4 Passenger sports auto-no allowance will be recognized.

Travel log(s) must be maintained for each vehicle in which a reimbursement allowance is recognized showing vehicle identification number, date, driver, beginning and

ending odometer readings, passenger names, except for group activities when the number of patients must be recorded, destination and purpose of travel. If the travel logs indicate less than 100% nursing facility business use, only the percentage attributable to nursing facility business use will be recognized.

Expenditures for gas, oil, repairs of transportation vehicles will be allowable to the extent of the number of vehicles permissible under the principles. However, in all cases, the Department of Human Services reserves the right to make the determination of entitlement based upon the facts in each instance. The number of Medicaid patients and the nature of the service provided by a facility will be considered in this determination.

REAL ESTATE AND PERSONAL PROPERTY TAXES

For Medicaid purposes, the allowable real estate and personal property taxes will be the four quarterly amounts due and payable during the reporting year or the tax based upon the assessed valuations of the prior December 31. For example, the amount allowable for calendar year 2001 will be the four quarterly installments due and payable during calendar year 2001 or the total tax based on the December 31, 2000 valuations. The basis for reporting will be determined by the provider but must remain consistent from year to year.

PERSONNEL COSTS

Compensation of Owners

Compensation to an owner or related individual must be reasonable and associated

with patient care in order to be reimbursable.

Criteria for Determining Reasonable Compensation to Owners and/or Related Individuals

In judging for reasonableness, the Chief Long Term Care Reimbursement may use but is not limited to:

1. Comparison with payments to individuals, other than owners, in comparable facilities or industries.

2. Equating responsibilities and functions performed with a satisfactory salary range.

The allowance for fringe benefits must be consistent with the compensation above.

Compensation of Administrators

An administrator must be a duly licensed person in the State of Rhode Island and be responsible for the overall management and supervision of a facility. Administrators must work on a full time basis and be substantiated by appropriate time records. Assistant Administrators working full time or part time must also be substantiated by time records. Compensation of an administrator is an allowable cost to the extent it does not exceed established maximums governed by bed capacity as shown on the attached schedule, Appendix ~~'B''~~A'. ~~Effective September 1, 1996 Nursing Facilities with a licensed bed compliment of 75 beds or less will be reimbursed based on current allowable costs for the administrator's salary. Said reimbursement will be subject to the ceiling maximums and the provisions as outlined below.~~

~~A Nursing Facility with a licensed bed compliment of 75 beds or less that is not fully recognized for reimbursement for the administrator's salary because of the Management~~

~~Related cost center maximum and whose actual cost is equal to or less than the limitations on Appendix 'B'~~ 'A'~~, and is reimbursed for an amount less than the Direct Labor Expenses cost center maximum can receive an amount up to 50 percent of the difference between the Direct Labor cost center maximum and the rate assigned in that cost center to accommodate up to the full administrators salary.~~

Appendix ~~'B'~~ 'A'will be adjusted annually commencing July 1, 2005 by the amount of percentage change reflected by the Wage and Salary Component of the National Nursing Home Input Price Index as projected by the Centers for Medicare and Medicaid Services for the twelve-month period ending the previous March.

Facilities Operated by Members of a Religious Order

The recognized salary allowance for members of a religious order providing patient care services will be limited to the lower of actual stipend paid on their behalf or the salary equivalent that would be recognized by these Principles of Reimbursement for similar services.

PROFESSIONAL SERVICES

The fees must meet the test of reasonable costs, and must be fully documented by billing which clearly describes the nature of the services rendered.

An example of admissible cost is the fee for legal services in connection with a directive to comply with fire codes regulations. A legal or accounting charge resulting from a buy/sell agreement between related parties is inadmissable. Professional fees associated with future construction must be deferred and included with the project construction costs.

FRINGE BENEFITS

Fringe benefits such as prepaid health insurance, group life insurance, employees child day care, dental plans, and retirement plans, are allowable costs, providing they are offered to all full-time employees. Similar benefits or partial benefits offered to all permanent part-time employees working at least twenty hours per week will also be recognized. Fringe benefits which advantage officers, owners, or other related individuals in a disproportionate manner will be adjusted to reflect equity of application. Fringe benefits by employee classification must be addressed in the facility's personnel and policy manual in order to be recognized. Benefits other than those stated above must have the prior written approval of the Rate Setting Unit and must be reasonable and necessary for the efficient, effective and economical operation of similar facilities participating in the Rhode Island Medicaid Program.

New fringe benefits provided to full time and permanent part time employees working at least twenty hours per week during a facility's base year will be annualized for prospective calendar years if the cost of the new benefit during the base year was less than a twelve month period. Upgrading and/or substitution of benefits does not qualify for this provision. New fringe benefits must continue through prospective years otherwise a rate reduction will be assigned retroactive to the date benefits were discontinued.

Vacation time and sick leave time are not recognized for reimbursement under the accrual method of accounting and will not be recognized for annualization of new fringe benefits. Vacation time and sick leave time will be recognized as an expense when actually paid to the employee by the facility.

Profit Sharing Plans: Profit sharing plans must continue in prospective periods at a

rate equal to the base period. Failure to fund at a level equal to the amount being reimbursed will result in a recovery of reimbursed costs. This will also result in a reduction to the assigned per diem rate of reimbursement.

OTHER OPERATING COSTS

All operating costs, including nursing, medicine chest, and over-the-counter drug supplies which have been determined as reasonable and acceptable will be allowed after reduction for items not related to patient care.

ACCOUNTING AND AUDITING FEES

Accounting and Auditing services are generally a necessary and proper function in the fiscal operation of long term care facilities. Recognized fees associated with these services must be clearly identified by the employed firm as to responsibility, function of activity, hourly billing rate and time element for each function. The Rate Setting Unit shall determine an appropriate amount for such services to be recognized for reimbursement purposes taking into consideration such factors as; facility employed accountant(s), controller(s), comptroller(s), bookkeeper(s), condition of books and records maintained by the facility, and the necessary direct involvement of the Accounting/Auditing firm.

ROUTINE SERVICES

Expenses pertaining to utilization review of all patients, physical therapy and other remedial therapeutic services will be accepted and considered as routine services for rate calculation.

Expenses pertaining to the services of a Behavior Health Specialist, who is licensed by the State of Rhode Island and is not eligible for direct reimbursement under the Rhode

Island Medical Assistance program, will be considered routine services and accepted for rate calculation.

EDUCATIONAL ACTIVITIES

The cost of approved educational activities of full-time employees will be included as an allowable cost provided that such activities are directly related to improving adequate patient care or the administration of the facility. In addition, the activity must be formally organized by a recognized school or organization approved by the State. Educational activities do not cover nurse's aide training and competency evaluation expenditures as these expenditures are not reimbursable through the Medicaid Program.

PHYSICIANS' FEES

Reasonable fees which pertain to utilization review, medical director, employees physical examinations and services required by OBRA-87 are considered allowable costs.

CONFERENCE EXPENSES

Reasonable expenses related to attendance at meetings and conferences may be allowable subject to the following conditions:

a. The program offered is approved as one which has the purpose of maintaining or improving the quality of patient care or administration within a facility.

b. The State shall determine whether there is a direct relationship between the job responsibilities of the person in attendance and the subject matter covered.

c. Attendance to major out-of-state conferences will be limited to two such conferences with not more than one person attending.

MEDICINE CHEST SUPPLIES, TRANSPORTATION AND LAUNDRY EXPENSES

The per diem and interim per diem rates that are established include the reported

expenses of nursing and medicine chest supplies, examples of which are, but not limited to, Appendix ~~'D'~~ 'B'.; transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories and hospitals for outpatient treatment; as well as laundry expenses including personal laundry with the exception of dry cleaning costs; therefore, facilities must not charge Title XIX patients or their relatives for these services.

INSURANCE

Generally acceptable insurance coverage for business enterprises including the types listed below are reimbursable:

1. Liability Insurance
2. Malpractice Insurance
3. Worker's Compensation
4. Property Insurance

Payment of health and life insurance premiums which provide benefits to an employee or his/her beneficiary are considered fringe benefits and should be claimed as such by the provider. Premiums related to insurance on the lives of officers and key employees which name the provider as beneficiary are not allowable costs. If the individual or his estate are beneficiary, the premiums can be considered compensation to the individual and the cost would be allowable to the extent his/her total compensation is reasonable.

Insurance costs applicable to transportation vehicles will be allowable to the extent of equivalent vehicle units permissible under the principles.

Mortgage insurance premiums are generally not an allowable cost. However, where the principal mortgagee specifically requires that the insurance be obtained as a prerequisite to completing financing arrangements and the insurance agreement stipulates that total proceeds must apply to the mortgage balance, then the premiums shall be reimbursable. ~~The proceeds so applied will be construed as allowed depreciation taken for reimbursement purposes.~~

START-UP COSTS

"Start-up costs" are defined for the Rhode Island Medicaid Program as those costs incurred for the operation and maintenance of a facility for a period not to exceed six weeks prior to the admission of the first patient. Such costs would include administration and nursing salaries, heat, gas, electricity, insurance, employee training costs (excluding nurse's aide training and competency evaluation expenditures), repairs and maintenance and any other allowable costs incident to the operation of the facility, but not interest, depreciation and real estate and personal property taxes. In as much as start-up costs would relate to services to patients subsequently admitted to the facility, they are considered to be deferred charges and amortization of these charges will be allowed over a period of 60 months.

COST NOT RELATED TO PATIENT CARE

The following are examples of, but not limited to, items which are not recognized for cost reimbursement purposes:

1. personal expenses,
2. items and services for which there is not legal obligation to pay,
3. business expense not related to patient care,

4. physician fees, prescription drugs and medications, as they are covered by means of a separate program,

5. reimbursed expenses,

6. costs of meals sold to visitors and employees,

7. costs of drugs, items and supplies sold to other patients,

8. cost of operation of a gift shop intended to produce a profit. Where expenses cannot be specifically identified the revenue derived will be used to reduce the total operating expenses of the facility.

9. expenses which exceed amounts under the prudent buyer concept,

10. accrued expenses not paid within 90 calendar days after close of the reporting period, except for bankruptcy proceedings, or at time of the audit, examples are but not limited to:

a. professional services including attorney and accounting fees,

b. unpaid compensation of employees, officers and directors owning stock in a closely-held corporation,

c. fringe benefits,

d. consultant fees,

e. suppliers and vendors,

f. trade association dues,

Any accrued expenses so disallowed will, however, be recognized when eventually paid by adjusting the costs of the year in which the expense was incurred.

11. State and Federal income taxes,
12. directory and display advertising or other means of advertising,
13. bad debts,
14. management fees,
15. expenses attributed to anti union activities as specified in H.I.M.-15,
16. excessive purchases of supplies when compared to previous years and years subsequent to base years,
17. employment agency fees/agency contract for purpose of recruitment,
18. costs of beepers,
19. costs of telephone in motor vehicles, and,
20. costs of nurse aide training and competency evaluations.

The inclusion of cost such as those set forth in 1-20 above, which are not related to patient care may constitute a violation of General Laws Section 40-8.2-4, as well as other provisions of State and Federal law and may result in criminal and civil sanctions and possible exclusion from participation in the Medicaid Program.

The State reserves the right to make determinations of admissible and/or inadmissable costs in areas not specifically covered in the principles.

SERVICE AND AFFILIATED ORGANIZATIONS

General

Any company or business entity which provides products and/or services to an affiliated nursing home or group of homes, where common ownership exists, must be

reported to the Rate Setting Unit in order to meet reimbursement requirements.

Reporting Requirements

The report form must be filed for approval. Data required will include but not be limited to:

a. explanation of the need for such an organization,

b. ownership interest and legal form of organization,

c. type of product or services to be rendered,

d. names of all affiliated facilities to be serviced.

Requests for approval must be filed in advance of the calendar year in which the service and/or affiliated organization provides billable services. This will allow for a determination of whether or not charges from the related service company to the nursing facility will be allowed.

The State requires in addition to the BM-64, the following:

a. financial statements of the related service company,

b. tax returns if above statements are not available.

If centralized services such as accounting, purchasing, administration, etc., are involved, complete details regarding the allocation of charges must be provided.

Cost applicable to services, facilities and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Costs include those actually incurred to which may be added reasonable handling and administrative charges. Profit add-on in the form of

markups or by other means is not permitted nor acceptable for reimbursement under the Rhode Island Medical Assistance Program, Title XIX, Medicaid.

HOME OFFICE CHARGES

Long Term Care facilities sometimes operate through a central home office resulting in home office charges. Cost-related expenses may be reimbursable providing that said central home office is physically located within the State of Rhode Island and if they can satisfy the reasonable cost-related concept previously described and if they can demonstrate and document that central management, purchasing and accounting services were uniformly performed for all facilities. Home office cost-related expenses, if the above is satisfied, will be pro-rated to each facility and enterprise for which services are being provided. The central home office must prepare and file with the Rate Setting Unit a cost report annually, in an approved format showing line-cost and allocation to each facility or enterprise. Additionally each enterprise for which services are provided must be fully disclosed.

A central home office established on or after January 1, 1985 must obtain prior written approval from the Rate Setting Unit in order to qualify to have its allocated costs recognized for reimbursement.

In-State Central/Home Office

Cost will be allocated and reimbursed through the ~~Management Related Expenses cost center and All Other Expenses cost center~~ Other Operating Cost Center. An In-State Central Office requires maintaining a minimum of three (3) Nursing Care Facilities and must be in operation and approved by July 1, 2004 for consideration for reimbursement.

Out-of-State Central/Home Office

Charges will be recognized to the extent of the lesser of reported reasonable costs of

central home office plus costs in Account No.'s 7421-Other Administrative Salaries, No. 7435 – Computerized Payroll Data Processing ,No. 7436-Accounting and Auditing Fees or the average allowable amount for facilities of like size and licensure for Account No.'s 7421-Other Administrative Salaries, No 7435-Computerized Payroll and Data Processing Charges and No. 7436-Accounting and Auditing Fees. The acceptable amount will be allowed in the ~~Management Related Expenses~~ Other Operating cost center.

Changes in Bed Capacity

Facilities in which the bed capacity is either substantially increased or decreased will be re-evaluated insofar as the reimbursement rate, and such change in rate, if at all, will be made retroactive to the date in which such change in bed capacity was authorized by the licensing authority.

Excess Bed Capacity

Per diem rates will be based upon the actual percentage occupancy of the facility's total licensed bed capacity in the base year or 98 percent of the statewide average occupancy rate in the prior calendar year, whichever is greater. For those facilities being licensed for only a portion of their potential bed complement, the 98 percent of the statewide average occupancy rate of the prior calendar year will be based on the available bed days of the portion licensed. However, expenses relating to the physical plant of such facilities such as, but not limited to the following, ~~interest, depreciation~~ Fair Rental Value System, if applicable, and real estate and personal property taxes will be allowed only as they apply to the licensed portion on a per diem predicated upon actual occupancy or 98 percent of the statewide average occupancy rate of the prior calendar year, of total potential bed complement of the facility, whichever is greater.

Transactions which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact, reductions of previously incurred costs or are added revenue associated with the business purposes of the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts and allowances received on purchased goods or services must be netted against the purchase price.

Quality of Care And Cost Incentives

The Department will pay a differential reimbursement rate of $ 200.00 to providers of service who provide ventilator beds at their facilities. This rate will be in addition to the per diem rate assigned for actual days a resident requires this service, and the rate will only apply to those resident days that are supported by a physician order. This amount will be limited to a maximum of ten (10) beds on a statewide basis and a facility must meet the following criteria:

- The facility must be Medicare-certified.
- The facility must have a minimum of five (5) ventilator beds, and

- The facility must have a licensed Respiratory Therapist on staff or under contract.

The facility must request and receive approval for the differential reimbursement rate in writing from the Rate Setting Unit.